Acko Health II
PROPOSAL FORM

FOR OFFICE USE

Branch Name: _____	**Branch Code:** _____
Intermediary Name: _____	**Intermediary Code:** _____
Business Type: _____	**Channel Type:** _____
Proposal Form No.: _____	**Intermediary Contact:** _____
POSP Name: _____	**POSP Code:** _____

Fields Marked as (*) are mandatory field.

I. PROPOSER DETAILS:

- *Name: _____
- *Gender: Male / Female / Third Gender
- *Marital Status: Single / Married / Divorced / Widow(er) / Separated (*Only for single adult proposal)*
- Nationality: Indian / Others (please specify) _____
- Residential Status: Indian Resident / Non-Indian Resident
- *Date of Birth: DD/MM/YYYY
- Occupation: Salaried / Self Employed / Professional / Others (please specify) _____
- Educational Qualifications: Lesser than Matriculation / Matriculation / Graduate /Post graduate / Professional course
- Existing Customer – Yes/No
- Annual Income: <5lacs / Between 5-10lacs / Between 10-20lacs / >20lacs
- PAN No.: _____ (PAN no. is mandatory in case premium is greater than ₹ 1,00,000)
- Passport No.: ____ Aadhar No.: _____Other Identification Proof (please specify): _____
- Form 60 (only in case the customer does not have PAN no): Yes / NO
- GSTN Registration Status: Consumer / Registered Dealer / Compounding Dealer
- GSTN Number: _____ (mandatory for Registered Dealer & Compounding Dealer)
- Permanent Address: _____
  City / Town: _____ State: _____ Pin Code: _____
- Correspondence Address: _____
  *City / Town: _____ *State: _____ *Pin Code: _____
- Telephone Number: *Mobile: _____ Office (*Optional*): _____
  E-mail: ID 1 _____ ID 2 _____

II. DETAILS OF INSURED PERSONS

	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
*Name (Mr. / Mrs./ Ms.)					
*Relation with the Proposer					
*Date of Birth	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
*Gender					
Blood Group					
Occupation					
Marital status					
Height (feet/ inch)					
Weight (kgs)					
Aadhar / PAN No.					
Annual Income					
Educational Qualifications					

Are all insured Indian nationals and Indian residents? Yes/ No

III. FAMILY PHYSICIAN DETAILS:

- Name: _____
- Mobile Number: _____
- Email: _____

IV. *DETAILS OF INSURANCE / PLAN:

Benefit Type	Product Features	Benefit Opted	Benefit Options Available
Basic Benefit	Base Sum Insured		3lacs / 5lacs / 10lacs / 15lacs / 20lacs / 25lacs / 50lacs / 1cr / 1.5cr / 2.5cr / 5cr / 10cr / Unlimited
	Sum Insured Basis		Individual / Floater
	Policy Tenure		1 Year / 2 Years / 3 Years
	Room Rent/ ICU		Room Category: General Ward / Shared Room / Single AC Room / Upto SI
	Day Care Treatment		Covered upto SI
	Pre or Post Hospitalization Medical Expenses	Pre: _____Days	Pre: 30, 60, 90 Days
		Post: _____Days	Post: 60, 90, 120, 180 Days
	Road Ambulance Limit		1k / 2k / 3k / 4k / 5k / 6k / 7k / 8k / 9k / 10k / Upto Sum Insured
	Domestic Emergency Evacuation Limit		1lac / 2lacs / 3 lacs / 4 lacs / 5 lacs / 6 lacs / 7 lacs / 8 lacs / 9 lacs / 10 lacs / Upto Sum Insured
	Domiciliary treatment		Covered upto SI
	Organ donor expenses		Covered upto SI
	Second opinion		Covered upto SI
Basic Benefit Options	Worldwide In-patient Hospitalization		Yes / No
	Restore Sum Insured		Once for unrelated / Once for related and unrelated / Unlimited times for unrelated / Unlimited times for related and unrelated
	Cumulative Bonus		1X/2X/3X/4X/5X/10X
	No Claim Bonus Sum Insured	____% of Basic Sum Insured	5% / 10% / 15% / 20% / 25% / 50%
	No Claim Discount		5%/10%/15%/20%
	First Notification of Claim	Compulsory Co-pay: __%	10% / 15% / 20%
	Preferred Providers Network	Compulsory Co-pay: __%	10% / 15% / 20%
	Co-pay	Compulsory Co-pay: ____%	5% / 10% / 15%/ 20% / 25% / 30% / 40% / 50%
	Super Top-up	Deductible Amount: _____	In the range: 0.5 lacs to 25lacs
	Waiver of Non-payable Medical Expenses		Yes / No
	All Medically Necessary Hospitalization		Yes / No
	Reduction in Specific Illness Waiting Period-Comprehensive		1 Year/ 2 Year
	Reduction in Specific Illness Waiting Period-Essential		1 Year/ 2 Year
	Preventive Health Check-up		Once in a year/ Once in two year/ Once in three year
	Inflation Protect Sum Insured		5%/10%/15%/20%/25%/50%
			Yes / No

	Initial 30 days waiting period waiver		
Add-on Benefits	Doctor on Call**	No. of consultations allowed: _____	1/2/3/4/5/6/7/8/9/10/ Unlimited
	Family Physician**	No. of consultations allowed: _____	1/2/3/4/5/6/7/8/9/10/ Unlimited
	Out-Patient Department (OPD) Medical Services**		1. Consultations: 1/ 2/3/4/5/6/7/8/9/10/ Unlimited
			Per consultation limit: Rs 250 / 500 / 750 / 1000 / 1500 / Unlimited
			2. Prescribed Diagnostic Tests: 1/ 2/3/4/5/ Unlimited
			Per diagnostic test limit: Per pharmacy limit: Rs 500 / 750 / 1000 / 1500 / 2500 / Unlimited
			3. Prescribed Pharmacy: 1/3/4/6/7/9/10/12/13/15/ Unlimited
			Per pharmacy limit: Rs 500 / 750 / 1000 / 1500 / 2000 / 2500 / 3000 / Unlimited
			4. OPD Treatment:
			No. of Treatment covered: 1/ 2/3/4/5/6/7/8/9/10/ Unlimited
			Limit: 5k/10k//20k/25k/ Unlimited
	Access to Our Put-Patient Medical Services Network	Discount: _____%	10% / 20% / 30% / 40% /50%
	Monthly No Claim Bonus OPD Sum Insured	Rs _____ per month	Rs 100 / 150 / 200 / 250 / 300 / 350 / 400 / 450 / 500
	Daily Hospital Cash	Rs _____ per Day	Rs 500 / 1000 / 1500 / 2000 / 2500 / 3000 / 4000 / 5000 / 7000 / 8000 / 9000 / 10000
	Accidental Death or Disability Cover		Yes / No
	Accidental Disability Cover		Yes / No
	Value Added Services		1. e-Consultation
			2. Wellness Coach
			3. Lab Services (Home Collection)
			4. Pharmacy (Home Delivery)
			5. Vital/Physical Activity Monitoring Services
			6. Reminder Notifications
			7. Medical Wallet
			8. Report Aggregation
			9. Home Care Services
			10. Ambulance Arrangement Services
			11. Pick-up and Drop Services for Consultation
			12. Prioritizing Appointments

**Note: The choice of limit is on a per person basis but counts limits will float within a family.

Personal Accident:

Product Features	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Benefit Options Available
Accidental Death or Disability Cover*						3lacs/ 5lacs/ 10lacs/ 15lacs/ 20lacs/ 25lacs/ 50 Lakh/ 1 Crore/ 3 Crore
Accidental Disability Cover*						3lacs/ 5lacs/ 10lacs/ 15lacs/ 20lacs/ 25lacs/ 50 Lakh/ 1 Crore/ 3 Crore

*Customer can choose only one benefit between "Accidental Death or Disability Cover" and "Accidental Disability Cover"

***Waiting Period:**

Insured name	Specific Illness Waiting	Options available
Insured 1	Yrs	1 Yr / 2 Yrs
Insured 2	Yrs	1 Yr / 2 Yrs
Insured 3	Yrs	1 Yr / 2 Yrs
Insured 4	Yrs	1 Yr / 2 Yrs
Insured 5	Yrs	1 Yr / 2 Yrs

V. NOMINEE DETAILS:

Nominee Name	Date of Birth	Relationship with the Proposer	Address and contact details of Nominee
Appointee Name (if the nominee is age of 18 years or less):	Date of Birth	Relationship with Minor	Address and contact details of Appointee

(In event of death of the proposer any payment due under the policy shall become payable to the Nominee proposed in the proposal form. The receipt of proceeds by the nominee would be sufficient discharge of the company. The nominee of all the other parson(s) proposed to be insured shall be the proposer himself / herself. Nominee Details is mandatory for "Accidental Death or Disability Cover" and "Accidental Disability Cover")

VI. DETAILS OF OTHER HEALTH INSURANCE POLICIES IN EXISTANCE:

Name of Insured Person	Insurer Name	Policy Number	Type of Cover	Policy Period	Sum Insured (₹)	Claims lodged during Policy Period (Yes/No)
Insured 1						
Insured 2						
Insured 3						
Insured 4						
Insured 5						

VII. *PREVIOUS INSURER DETAILS (only applicable for Portability Policies)

Please provide your previous insurer policy copy in case of portability.

VIII. PREMIUM PAYMENT DETAILS

- *Mode of Payment: _____
- *Frequency of Payment: Monthly / Quarterly / Half Yearly / Yearly

Instrument Name	Instrument Date	Instrument Amount (₹)	Name of Premium Payer	Relationship of Payer with Proposer	Bank Details

IX. BANK ACCOUNT DETAILS:

(Mandatory details required to process all payment due in relation to your policy including refunds (if any) and / or claims directly to your bank account.)

- Name as in Bank Account: _____
- Bank Name: _____ Account Number: _____
- Bank Branch: _____ IFSC Code*: _____
- Account Type (Saving/Current): _____ Bank City: _____

*Please enclose cancelled cheque along with the Proposal Form for direct payment in the account. In case the cheque doesn't bear a/c holder name or branch IFSC code or both, kindly fill the NEFT mandate form.

☐ Yes, I would like to opt for ECS** Payment option for Policy Renewal.

**We will use standard latest ECS format of RBI.

I/we hereby declare and undertake that the amount paid by me/us as premium for the aforementioned policy is out of my/our lawful and declared source of income.

Date: _____ Place: _____ Signature: _____

X. MEDICAL HISTORY OF INSURED PERSON(S)

Sr No.	Questions	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
1	Has an ailment or disability or deformity?	Y/N	Y/N	Y/N	Y/N	Y/N
2	Has a surgery planned?	Y/N	Y/N	Y/N	Y/N	Y/N
3	Takes medicines regularly?	Y/N	Y/N	Y/N	Y/N	Y/N
4	Has been advised investigation or further tests?	Y/N	Y/N	Y/N	Y/N	Y/N
5	Was hospitalized in the past?	Y/N	Y/N	Y/N	Y/N	Y/N
6	Is expecting a baby (Only for females)?	Y/N	Y/N	Y/N	Y/N	Y/N
7	Any lifestyle habits?	Y/N	Y/N	Y/N	Y/N	Y/N

Sr No.	if yes for Q1, suffering from ailment / disability / deformity	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
1	Hypertension / High Blood Pressure	Y/N	Y/N	Y/N	Y/N	Y/N
2	Diabetes / High Blood Sugar/ Sugar in Urine	Y/N	Y/N	Y/N	Y/N	Y/N
3	Cancer, Tumor, growth or Cyst of any kind	Y/N	Y/N	Y/N	Y/N	Y/N
4	Chest pain / Heart Attack or any other Heart Disease / Problem	Y/N	Y/N	Y/N	Y/N	Y/N
5	Liver Diseases / Gall Bladder Problems / Jaundice / Hepatitis B or C	Y/N	Y/N	Y/N	Y/N	Y/N
6	Kidney Disease / Problems	Y/N	Y/N	Y/N	Y/N	Y/N
7	Diseases of Male / Female reproductive Organs	Y/N	Y/N	Y/N	Y/N	Y/N
8	Tuberculosis / Asthma or any other Lung Disorder	Y/N	Y/N	Y/N	Y/N	Y/N
9	Ulcer (Stomach / Duodenal), or any problems of Digestive system	Y/N	Y/N	Y/N	Y/N	Y/N
10	Any Blood Disorder (E.G. Anemia, Hemophilia, Thalassemia)	Y/N	Y/N	Y/N	Y/N	Y/N
11	Any Genetic disorders	Y/N	Y/N	Y/N	Y/N	Y/N
12	HIV Infection / AIDS or Positive Test For HIV	Y/N	Y/N	Y/N	Y/N	Y/N
13	Nervous, Psychiatric or Mental or Sleep Disorder	Y/N	Y/N	Y/N	Y/N	Y/N
14	Stroke/ Paralysis/ Epilepsy (Fits) or any Other Nervous disorders (Brain/	Y/N	Y/N	Y/N	Y/N	Y/N
15	Abnormal Thyroid Function/ Goiter or any Endocrine organ disorders	Y/N	Y/N	Y/N	Y/N	Y/N
16	Eye or vision disorders/ Ear/ Nose or Throat Disease	Y/N	Y/N	Y/N	Y/N	Y/N
17	Arthritis, Spondylosis, Fracture or any Other disorder of Muscle Bone/ Joint/ Ligament/ cartilage	Y/N	Y/N	Y/N	Y/N	Y/N
18	Any other ailment/ disease or condition not mentioned above	Y/N	Y/N	Y/N	Y/N	Y/N

Sr No.	If Yes (for Q.1,2,3,4,5) for above then Details are required as below	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
1	Exact Diagnosis					
2	Diagnosis Date					
3	Consultation Date					
4	Current Status					
5	Medicine Details					

Sr No.	If Yes (for Q.6) for above then Details are required as below	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
1	Please provide expected date of delivery (EDD)					

Sr No.	If Yes (for Q.7) for above then Details are required as below	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
1	Cigarette/Bidi/ (How many per week)					
2	Tobacco/Gutka (How many times per week)					
3	Alcohol (How much ml(quantity) per week)					
4	Narcotics/ Drugs (How many times per year)					

Note: This may be changed based on underwriting experience of the cohorts with approval from chief underwriter and appointed actuary.

XI. DECLARATION & WARRANTY ON BEHALF OF ALL PERSONS PROPOSED TO BE INSURED

1. I hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge and that I am authorised to propose on behalf of these other persons.

2. I understand that the information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurer and that the policy will come into force only after full payment of the premium chargeable.

3. I further declare that I will notify in writing any change occurring in the occupation or general health of the life to be insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the company.

4. I declare that I consent to the company medical information from any doctor or hospital who/which at any time has attended on the person to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured /proposer has been made for the purpose of underwriting the proposal and/or claim settlement.

5. I authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and / or claims settlement and with any Governmental and / or Regulatory authority.

XII. OTHER DECLARATIONS & AUTHORIZATIONS

1. I hereby permit/ authorise Acko General Insurance to collect, store, communicate and process information relating to the policy(ies)and all transactions related therewith, including the sharing and disclosing the public authorities, of any confidential information as required by law and to send me information in relation to the Policy and Acko General Insurance products & services, irrespective of whether I am registered with National Customer Preference Register (NCPR) [(Formerly the National Do Not Call Registry (NDNC)] or not.

2. To protect the environment and save paper, I hereby give my consent to Acko General Insurance to send me the executed policy copy and all related documents and other communications in electronic form by way of email to the aforesaid email id instead of physical form and to share all such documents and any updates & alerts via Whatsapp on my registered mobile number with the company.

I submit that the foregoing information is true to the best of my knowledge and accept that if found to be untrue in any form, the Company reserves the right to alter/ cancel the coverage available under this Policy.
Note: The liability of the Company does not commence until full premium has been realized by the Company and the acceptance of the proposal has been formally intimated to the insured.

Date: _____

Place: _____ Signature of the Proposer: _____
(On behalf of all the persons to be insured under the Policy)

XIII. SALESPERSON/INSURANCE AGENT/INTERMEDIARY DECLARATION

I, _____(Full Name) in my capacity as an insurance Agent/ Specified Person of the Corporate Agent/authorized employee of the Broker or authorized Sales Person of the Company, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the contract of insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy.

I have further explained that if any untrue statement(s)/information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the Policy issued to his/her favour pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the Company.

License No. / ID (*Agent / Corporate Agent / Broker / Salesperson*): _____

Date: _____ Signature of Proposer/ Intermediary: _____
Place: _____

XIV. PROHIBITION OF REBATES (SECTION 41 OF INSURANCE ACT, 1938, AS AMENDED)

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the prospectus or tables of the insurers.

2. Any person making default in complying with the provisions of this section shall be liable for penalty which may extend to 10 lakh rupees.

XV. ELECTRONIC INSURANCE ACCOUNT DETAILS OF PROPOSER (E-mail id is mandatory)

- Do you wish to have this policy credited to an e-Insurance Account (eIA) of an Insurance Repository? Yes/No

- If you have an eIA, please provide following details:
  Name of Insurance Repository: _____
  eIA No.: _____
  Name as appearing in eIA: _____

- If you do not have an eIA, would you like to open an account? Yes/No
- If Yes, Choose any one Insurance repository:

  NDML- NSDL Data Management Limited; or
  CIRL- Central Insurance Repository Limited (CDSL); or
  Karvy Insurance Repository Limited (KARVY); or
  CAMSRep- CAMS Repository Services Limited.

- Help us preserve the environment by opting to receive policy related information in soft copy/via email only: Yes/No
- Would you like to subscribe to important alert on WhatsApp? Yes / No

XVI. ACKNOWLEDGEMENT FOR PROPOSAL

Please retain this counterfoil for your records (on behalf of Acko General Insurance Limited)

We acknowledge the receipt of the payment of ₹ _____ vide Cash/DD/Cheque No. _____ from Mr/Ms _____. Please not that this is only acknowledgement receipt and does not amount to acceptance of risk or commencement of the policy. The Company is not liable for any claim between the time that the proposal amount is received, and Policy Start Date. The validity of this receipt is subject to the realization of the proposal amount. Acceptance of proposal and issuance of the policy shall be subject to receipt of the completed Proposal Form, premium payment, medical records (wherever applicable) and underwriting decision of the company.

Proposal No.: _____ Signature of the Representative: _____

Name of Representative: _____

Insurance is subject matter of solicitation.

Note: Should you choose to pay premium by Cash, you are advised to do so only at nearest Acko General Insurance Limited branch or any authorized bank branch, and we insist you to please ask for computerize receipt against the deposited cash against your Proposal. Any claim without computerized receipt against the deposited cash will not be admitted.